



Town of Ashburnham
Town Hall, 32 Main Street
Ashburnham, Massachusetts 01430
Tel. 978-827-4100 ext. 0
FAX 978-827-4105
www.ashburnham-ma.gov
Hardship Application Form

Patient Name: _____ Tel#: _____

Address: _____ City/Town: _____ Zip: _____

This application is to request to have the above patient's ambulance charges cancelled. To apply, please complete the questions below, sign and return in the enclosed envelope **within 28 days**.

If your income, based on family size, is less than those listed below, charges may be cancelled. Add an additional \$4180.00 for each person making family size over and above 8 people.

Proof of income MUST be attached to the completed form.

<u>Family Size</u>	<u>Annual Income</u>
1	\$12,060
2	\$16,240
3	\$20,420
4	\$24,600
5	\$28,780
6	\$32,960
7	\$37,140
8	\$41,320

1. What is your family size? (How many people live in your household?) _____
2. What is your total annual family income? (*When you add up all the money everyone in the household makes per year?*) _____
3. Are there any other unusual circumstances that you believe would justify a hardship waiver?

I certify under the pains and penalties of perjury that the above information is true and correct to the best of my knowledge:

Signature: _____ Phone # _____

Printed Name: _____

This application will be forwarded to the Town of Ashburnham for their review and determination.